DRUG PRIOR AUTHORIZATION FORM

County Medical Services Program in San Diego

PLEASE FAX COMPLETED FORM TO: (516) 403-2151 OR COMPLETE THE ON-LINE FORM AT WWW.NMHC.COM

NMHC* Customer Service Help Desk (800) 777-0074 Available 24 Hours a Day, Everyday

☐ URGENT REQUEST Fax to (516)403-2150 **NOTE**: Reserved for requests that are potentially life-threatening or poses a significant risk to the continuous care of the patient, NMHC* Clinical Pharmacists reserve judgment of the urgency and request explanation/reasons be stated below.

Name of Member's Program: ☐ CMS ☐ RW ☐ CI	Date of Request:
Patient Name (Last, First, MI):	Patient SSN:
Sex: ☐ Male ☐ Female DOB:	Patient Phone Number:
Physician Name:	
MD Office Contact Person:	Physician's Specialty:
Physician's Fax Number:	Physician's Phone Number:
Physician's ID:	Provider Signature:_____
Pharmacy Name:	Pharmacy Fax Number: ( )
Pharmacy Contact:	Pharmacy Phone Number: ( )
Pharmacy NABP #:	Provider Signature:_____

MEDICATION REQUEST

☐NEW ☐ RENEWAL RENEWAL ORIGINAL Rx DATE: _____

DIAGNOSIS (as it related to requested medication): _____

CURRENT MEDICATION(S): _____

_____

DRUG AND STRENGTH:_____ NDC: _____

DIRECTIONS: _____ MONTHLY QTY _____REFILLS: _____

FORMULARY DRUGS TRIED AND MEDICAL JUSTIFICATION: _____

_____

_____

----------PBM OFFICIAL USE ONLY----------

☐ Approved ☐ Denied ☐ Deferred for Additional Information ☐ Approved As Modified Pt. Not Eligible

COMMENTS: _____

_____

PBM Authorizing Signature _____ **Date** _____

*NMHC is transitioning into informedRx® **KEY:** RW denotes Ryan White Primary Care CI denotes Coverage Initiative